Suicides Anonymous

Liberty at Death's Door

Seth Edward Many, M.D.

Contents

Fast-Forward: 2009, 2nd Edition

When *Suicides Anonymous. A Case Study in the Ethics of Organization* emerged in 1969, one publication, "The Radical Therapist, A Journal of Opinion" (ed. Michael Glenn) expressed interest on the condition that I might "boil down" certain sections (or the whole) to about 15 pages. Such radical therapy felt more like radical surgery, but no publisher, except the vanity "Philosophical Library" prodded me "to bring this project to a conclusion." One sympathetic friend, Michael Finn of our Cambridge commune, did acclaim its value as a bed-time soporific and graciously had several copies printed for distribution.

Recognizing the substantial editing required, and the unforgiving keys of my old Smith-Corona, it remained still-born. Now, on this 40th anniversary of that first printing, advances in scanning, word-recognition, word-processing, and web publication encourage redress of that neglect. So here it is, renamed, repaginated, and reissued with (hopefully) clarified thought. Still, its form is pretty-much unaltered (down to sub-section end-citations), and its substance neither quenched nor quelled by time and social change.

But one aspect comes into perspective. I now acknowledge and thank a remarkable support network of friends, volunteers, libertarians, and professionals who enabled *Suicides Anonymous*, the agency, in conducting its own brief skirmish with expansive professional incursions into protected civil space. Volunteers and clients must of course remain unnamed, but belated special thanks to friend

and attorney Carolyn Peck, the "Amelia Earhart of courtroom dress" after a NYS Appellate reversal (counseled by Faith Seidenberg) of her 1969 Syracuse court exclusion for appearance in a min-skirt.[1]

Other must-mentions are Julian Friedman (regional ACLU founder and political-science professor at SU/Syracuse University), Jack Douglas (SU sociologist and author of the "Social Meanings of Suicide"), and the singular cadre of ethically-engaged psychiatrists at Upstate Medical Center including Robert Daly, Eugene Kaplan, Chaitan Haldipur, Robert Seidenberg, and Shirley Rubert. Most especially, I acknowledge Thomas Szasz of that same department, who offered quiet encouragement in this project and more, and to whom this book is hereby dedicated.

Seth Many
Sharon Springs, NY
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[1] **Margolick "At the Bar" *NY Times* 17 Jan 1992; Peck v. Stone. NYS Appellate Div. (4d) 30 Oct 1969**

Introduction

The development of ethical organization is a task of critical import facing a mixed multitude of persons starving for justice and striving for meaning. The annihilation of meaningful human life is the result of both conscious and unconscionable maneuvers and manipulations of agencies and states seeking the advancement of institutional self-interest in the name of public welfare. To retain that basic vestige of humanity, life with the possibility of meaning, the limited focus of helper agencies must give way to a central concern with principled action and non-violent solutions.

Under the shabby disguise of divine sanction, national imperative, technological superiority, or professional benevolence; interminably racist and discriminatory scapegoating of the displaced, inept, poor, weak, uncultured, and different goes on unabated. Both moral and unprincipled persons and organizations stigmatize, banish jail, enslave, and slaughter those holding divergent valued property amidst divergent values, as at Songmy in Vietnam.

The nihilist psyche specializes in violence; the legalist in coercion. It is not just guns, but rules and games, agencies and institutions, corporations and notions which intimidate and deploy, striving to invalidate and destroy those who seek life with a semblance of social

equality, peace and justice, honesty and love.

The rationale and premises of political institutions during the term of the 'Great American Experiment' have been subject to recurrent examination. Central to these revisions are attempts to identify and crystallize the ethical presuppositions underlying diverse social traditions in all spheres of public and private interaction.(1, Billington)

The transition of America from religious diversity to secular homogeneity, has been paralleled by the development of a new task force of social and spiritual healers, heralding an age of "sociatry." Thus the movement of psychiatry from a silent Cerberus, guarding the shadowy gates of state hospitals or dispelling the unconscious dark on private psychoanalytic couches, to an aggrandizing polity, deeply and forcibly committed to directing community mental health, serves to emphasize the necessity for critical ethical inspection.

Braceland has argued that this country again faces a crucial social realignment in which psychiatry will play a central role.(2, Braceland) This thrust for realignment comes both from an eager and expectant populace who believe in their right to health, and the recent extension of Federal legislation responsive to the Community Mental Health movement and enhanced support of the National Institutes of Mental Health.

The development of specialized professional roles in

the arena of mental illness/health is acquiring some aspects of the "Big Bang" - the creation of a new universe of services with innumerable constellations competing for public Interest and public monies. The rapid differentiation of de novo subspecialties, creating their own brand of psychiatric obsolescence, is supported by the proliferation of special paraprofessionals, aids, counselors, etc. In this luminous atmosphere, no star burns brighter than that of suicidology, the profession of specialists in suicide behavior and prevention.

Seeking fellows from a variety of social and behavioral disciplines (psychology, psychiatry, anthropology, sociology, social work, public health nursing, health education, etc.), suicidology bids fair to serve as a conglomerate model for the development of a flock of new government spawned professions. The curriculum promotes and provides

"instruction in crisis intervention, psychological and sociological aspects of suicide, treatment, therapy of suicidal individuals and the psychological autopsy." (3, Bulletin of Suicidology)

This new professional conglomerate draws sustenance and legitimization from its domicile in the house of science. Yet a significant contingent of social scientists uneasily question its place therein. They would annul the false marriage of fact and value in the name of science not only because psychiatry sacrifices democratic process, but because rational social order is founded in citizen

awareness of ethical issues and conflicts. Recognizing the facts of institutional and agency practice is an indispensable precondition of free and reasoned judgment concerning its place and value in our own lives.

In the following pages I take a close look at one agency, Suicides Anonymous, formed to respond to callers considering or thinking about or planning suicide. It is a study in the ethics of organization. But it is also an agency at the crucial intersection of social philosophy and social action. The radical separation of education from the social conditions of suicide contributed to a despair and innovation paralysis which characterizes the individual in confrontation with established systems. Recent attempts to reinvolve the student in the experience behind the symbol, suffer from an anti-intellectual character born of this despair. But perhaps even more, they suffer from pervasive fatalism which derails attempts to reconnect action and mentation.

Section I. Suicides Anonymous. The priority of applied philosophy - the application of standards and principles to a specific agency operating in a specific context.

Section II. Suicide and Social Control. Issues involved in the social control of suicide: A. Suicide. What is it? Intentions, outcomes, social meanings, confusions of fact, interpretation, and value; B. Prevention. Agency presumptions, goals, instruments and

tactics; especially devolved police powers; and C. Suicide Prevention. Metaphorical extensions: "prodrome" and "autopsy" (medical-psychological), "cry for help" (psycho dynamic) and "depression" (psychiatric diagnostic); D. Organizing for Liberty. Medical and community mental health models and modules; scientific-therapeutic context; voluntary association alternatives.

Section III. Ethics of Agency. Central issues embedded in organization goals, structure, and operation; redressing imbalance between institutional vs. individual interest; elements that enhance rather than preempt individual capacity for awareness and voluntary agreement.

Individual civil liberty acknowledged and affirmed is an antidote to intimidation, implied threats, and coercive tactics which exaggerate powerlessness and encourage suicidal consideration and intention. The goal of Suicides Anonymous is to establish just those organizational conditions which affirm life with the mutuality, respect, and liberty due to all its participants.

Seth Edward Many
Cambridge, Massachusetts
Dec.1, 1969

Citations (intro)

1. Billington, R.; Loewenberg, BJ; Brockunler,S. The Making of American Democracy, Vol. II., Rhinehart and Co., N.Y., 1950

2. Braceland, F. "The Relationship of Psychiatry to Medicine," Psychiatry Digest 30(4):12-16, April 1969

3. Bulletin of Suicidology (National Institutes of Mental Health) "Announcement: Fellowships in Suicidology," p.57, Dec. 1968

Section I. Suicides Anonymous

"...in every order of creation there are two sorts of creators, contrary yet complementary; one of which gives rise to seas and swimmers, the other to the Night-which-contains-the-seas and to What-waits-at-the-journey's-end: the former, in short, to destiny, the latter to destination..." (1, Barth) Lost in the Funhouse

Suicides Anonymous (SA) began swimming on November 6, 1967. Its entry into the sea of agency life was prompted by two phenomena: (a) social and workplace unconcern of persons for their fellows; and (b)a movement towards professional preemption of motive and action manifest in suicide prevention services. As to lack of concern:

> "Best of all, if you don't show up at the office or at a tea, nobody will bother their head...They will just think you're dead."(2, Nash)

Suicides Anonymous was born to be bothered. Its first concern was for fellow. But this concern was not, could not be professional. In the professional realm, newly empowered psychiatric divines, actuarial apologists, were making the scene. Armed with probabilities and portents, these new specialists sought the chalice of scientific respectability and the sword of state authority. Their methods were far from new:

> "We (the physicians) must protect the patient from his own wishes (in suicide and homicide)."(3, Solomon)

"We the psychiatrists) may have to impose treatments which at least temporarily help to reserve an oppressive

status quo."(4, Halleck)

"Suicide prevention is like fire prevention. It is the minimum ever-present peripheral responsibility of each professional and when the minimal signs are seen...there are no excuses for holding back on life-saving measures."(5, Schneidman)

The claims to professional eminent domain were troubling. SA propounded an alternative that did not rely upon expert claims, moral imperatives, or coercive authority. Our determination was service without imposition; interaction without intervention; love without power. We resolved for the client as the only court of appeal. His/her judgment, the final judgment.

Suicides Anonymous sought to exist not as a police or fire department, nor even an early warning device. Not as a Suicide Prevention Service, but as an elan vital, an affirmative life force, organization in the service of life.

Our list of conceptual rejects surpassed even the lists of those who rejected us. We sent back to the factory all current models: medical, ritual-deviance, labeling, theory model, etc.(6, Szasz) Not for repair. But for good. The defect was not in the machine, it was in machines. Not in a model, but in the modular approach.

Is someone out there mumbling anti-scientific anti-intellectual? Perhaps even a diagnosis: "modular

avoidance reaction." Yes, if you wish; where science and intellect take cold comfort:

"..It is of the essence of the scientific spirit to be mercilessly ascetic, to eliminate human enjoyment from our own relation to nature, to eliminate the human senses, and finally to eliminate the human brain..."(7, Brown)

Tom Lehrer tells a story about an urban apartment dweller who receives an urgent mail message:

"Come quickly, I can't stand it any longer. The razor is to my wrists, the pills are to my mouth. It is so lonely. Please come! (signed) 'Love'"

Distraught but determined, our hero pulls on his raincoat. It is a dark, gloomy day. But...where is he going? Slowly the note is examined, turned over. It is addressed to "occupant."

Where are we going in this suicide prevention machine? And who signs off on each new model, inevitably enhancing the designer's divine diagnosis. These models scapegoat, salve and soothe, sustain and exculpate (8, Schur). They benefit of the construction corps, not the passenger or pedestrian.

Where are we Going?

Ernest Schneidman is past head of the Los Angeles Suicide Prevention Agency and recent chief of the National Institute of Mental Health Center for Studies of Suicide Prevention. Following are five of his

favorite postulates.(9, Schneidman)

(1)Every suicidal individual wishes to be rescued;

(2)Suicidal behavior stems from a sense of isolation and intolerable feelings;

(3)unconscious intentions may erupt into "hints" or "prodromal" clues of the act to come;

(4)The rescuer has a minimal responsibility to prevent suicide;

(5) There are no excuses for holding back on lifesaving measures.

These articles of faith maintain and enhance the special "wisdom" and prerogatives of psychiatrists. They superintend the new medical discipline of "suicidology" a fresh grind of theory, value, and exhortation.

At best the assumptions are extraneous to agency provision for relationships characterized by warmth, genuiness, trust, mutuality, etc. At worst, they inhibit understanding through preconception and a priori definition, and serve to undermine the foundations upon which such relationships may be established. (10,Carkhuff) They provoke both primary and collateral personal damage through doctrines of collective responsibility, preemptive professional jurisdiction, manipulative intervention, and coercive prevention. One clear result is social fascism, government by managers; another, individual alienation; a third, the perpetuation of conditions of enforced ignorance,

domination and degradation.

Common and Uncommon Sense

Principles of self-determination and relationship are needed to dismantle distrust and dishonor embedded in professional systems of welfare delivery. To decode suicide communications a clear distinction between social relations and personal relations is necessary.(11, Buber) In the former, individuals are bound into group by commonality of experience or purpose; in the latter self-emergence is confirmed in the person of the other.

The conditions necessary for the development of personal relations are twofold: the first is "primal setting at a distance."(12, Friedman) The second is "entering into a relation."

"...we can enter into relation only with being that has been set at a distance from us and thereby has become an independent opposite...In human life together, it is the fact that man sets man at a distance and makes him independent that enables him to enter into relation, as an individual self..." (13, Buber)

Self-determination is conditioned upon respect for another's difference. It is the acknowledgment of independent others that opens the possibility of relation. Through relation, the conditions for the expression of individual life with meaning are potentiated.

Central feature of our technologic age are closure, definition, and fullness of specification. These functions encourage rapid resolutions and maximal operational efficiency. But such speed and conceptual rigor stifles ambiguity, amplifies interpersonal distance, and denigrates heuristic design.

"The heuristic approach to system design is one that uses principles to provide guides for action. It is not bound by preconception about the situations the system will encounter. Its principles provide action guides even in the face of completely unanticipated situations and in situations for which no formal model or analytic solution is available."(14, Boguslaw)

Response to unanticipated/emergent situations based upon model presumptions or preconceptions is a prominent feature of life/death situations:

"A mortician who practices in Fife
Made love to the corpse of his wife.
How could I know. Judge?
She was cold, did not budge-
Just the same as she acted in life." (Anon)

In the medical idiom, the cold immobility of the mortician's wife might be a "prodromal hint." But the mortician's preconception resists any fruitful solution.(15, Laing)

Agency contrasts

The speed/efficiency operating unit approach starts with personnel carefully selected and trained to possess defined performance characteristics and emphasizes

triage, i.e., differentiation-disposition. In contrast, Suicides Anonymous avoids selection and training. Our volunteers come from any stage or station, with varied sense, sensitivity, and dedication. In rejecting selection and training of volunteers we sought to engage individuals in self-resource initiation and personal problems solving.

SA was also intent upon reduce status discrepancies and role differentials that increase interpersonal distance. Social isolation and interpersonal distance are amplified by existing organizational structures emphasizing deference to professional authority or opinion. Deference is the flip-side of subordinate (inferior) judgment.

Community alienation

Some of the most devastating personal rebuffs are generated by agencies that "protectively" insulate clients from their native community. The physical isolation of large state mental hospitals is matched by social isolation in cities and suburbs. When groomed for personal advancement or professional deference, the local volunteer adds to this problem. The multiplication (splitting) of professional, para-professional, and non-professional roles is a major contributor to social isolation.

In-touch volunteers

Through individual contact, word of mouth, and public advertising Suicides Anonymous called for volunteers. A minimal qualification: courage to surmount the fear of contact with dismissal and despair. Although planned as part of a broader community effort (Onondaga County, NY), the initial appeal went out to the Syracuse University Community. This was a body rich in untapped energy, courage, and curiosity; many individuals deeply concerned with success/failure and self-determination.

The response was gratifying. Soon bimonthly meetings were being held. A reliable pool of about twenty volunteers commenced operation; volunteers although uncertain about the specification of their task, able at the minimum to accept the heuristics of self-determination, non-coercion, and equal relationship.

A local church ("The WatchTower") provided a small downtown office cubicle. The telephone company graciously granted a number with appropriate life-affirming connotation: GAB-1000 (422-1000). The no-nonsense direct contact telephone service resonated with SA's dedication to self-determination and relationship.

Other agencies emphasize delegation of authority or disposition as the resolution of telephonic inputs, whereby a volunteer is a conduit to a counselor, social worker, psychologist, a psychiatrist. If suicide is

imminent, the police are called. In a hierarchical organization every subordinate authority thus constitutes a barrier to interpersonal exchange. In Suicides Anonymous, the volunteer-client relationship is it. The anonymous telephone service enhances, not obstructs, mutual interaction. The telephone invites, demands, participation. (16, McLuhan)

The use of lay volunteers is well-precedented.(17, Harvey; 18, Holzberg) College students are deeply interested in sustained friendships; helper projects sometimes appropriate a troubled label, "Amicatherapy."(19, Michell) Collegiate clients having experienced both the limitations and lack of confidential aid, may become volunteers to fill the void.(20, Hirsh; 21, Schur; 22, Riessman)

Within the last decade a growing body of data supports the notion that lay helpers may provide services equal to, if not better than professionals under certain conditions.(23, Carkhuff) The burden of proof shifts then to the professional in its pre-emptive claim to unique capability in this realm of human services.

Community response and resistance

The birth trauma of Suicides Anonymous was not confined to difficulties in the logistics of client-volunteer development. Antipathy to the development of

an unaffiliated non-professional service organization generated a dismissive call from the local mental health association for "integration" of all such services. One year later this association made direct inquiries to Suicides Anonymous rather than listening to hearsay accounts. Despite our clarification of the very basic and fundamental differences, the association then proposed a merger with St. Joseph's Hospital Prevention Service, a traditional county-founded operation..

The Community Chest refused any grant of aid, claiming SA was neither duly recognized as a "helping" agency; nor qualified to receive funds until fully operational (for an unspecified length of time) and legally designated as a non-profit organization (fee payable to the State).

Local newspapers conducted a semi-blackout of SA operations despite repeated attempts by volunteers (enrolled in the Syracuse University School of Journalism) to insert items and articles. The Sunday Magazine, "Empire" suggested SA was not of sufficient general interest.

Several radio stations did offer discussion show participation which was readily accepted. But local television channels repeatedly refused to have anything to do with us. A discouraging example of their reticence came in the fall of 1968 when the local educational channel (UHP-24) refused to grant us any time either in

an ongoing series designed to review local mental health services, or to participate in a program featuring the St. Joseph's Suicide Prevention Service. SA made repeated attempts over four months to gain a voice. UHP-24 claimed "insufficient notice" for taping the shows. Unofficially SA was deemed "too controversial, not well enough established." On other occasions we encountered incredulity, suspicion, and hostility. In this, our experiences paralleled attempts to secure notice for autism sacrificed to rigid professional domains (mental health vs. developmental disability).(24, Graziano)

One major exception was coverage gained during a public conference sponsored by Suicides Anonymous, hosted at Syracuse University. Presenters included keynote speaker Thomas Szasz, and faculty from S.U. School of Law and the Department of Sociology.

My own department of Psychiatry (Upstate Medical Center at Syracuse) adopted a non-interference, disinterested posture. Although grateful for the former, the lack of interest seemed less appropriate. After a year of continuous SA operation the department graciously offered a segment at one of its weekly meetings. The Chairman was conspicuous by his absence, and the psychiatrist who introduced me withdrew from the meeting almost immediately. However, others were attentive and supportive.

Another exception to the pattern of organizational

hostility and obstruction came from the local chapter of the American Civil Liberties Union. The section on medical and human rights invited SA several times to participate in their meetings and to keep them informed of our development. This we gladly did.

Our main source of recognition continued to be on the Syracuse University campus. Through Weekly notices in the Daily Orange (the student newspaper), exposure on WAER campus radio, and signs and posters placed in bars, laundromats, street poles, and dorms. We maintained a small but steady flow of clients and volunteers. Among intimates, the service came to be fondly known as the "Night Ear."

The volunteer staff fluctuated in number and personnel turnover, especially in the early days of operation. As many as forty, as few as twelve volunteers manned the phones for the twelve hour per day, five days per week operation. In the last six months, the number of volunteers stabilized at around twenty persons, with a much lower turnover rate. Geographical distribution of volunteers, though centered in the University, was broad. One volunteer took calls in Skaneateles, a town about 15 miles from Syracuse. Volunteers were about equally divided between those with and those without University affiliation. Age ranged from 16 through 55. Males were rather evenly matched by females.

By and large the volunteers tended to be most

interested in manning the phones. There was little interest in advertising, administration of the organization, or the development of subsidiary goals or programs. The group remained devoted to its primary task of serving the client rather than the organization.

Leadership and Organization

Initial organization blueprints and modest costs (telephone service, ads, notices, etc.) we met by myself. Carolyn R. Peck, a friend and local poverty law attorning was highly supportive. Her occasional presence at SA meetings helped with volunteer legal liability concerns; especially "what if I get sued?" As established volunteers demonstrated thoughtful responsivity, qualms of new volunteers were handled in peer discussion rather than through appeal to legal or other authority.

Principled action (self-determination, non-coercion, and relation) and common sense were applied not only in the volunteer-client context, but also with regard to the minimal leadership-volunteer structure. Volunteers were expected to exercise their own judgment, but to recognize that their advice offered might justifiably be disregarded.

Initial administrative tasks including policy queries, scheduling, meeting formation, and publicity, (financing excepted) gradually moved to willing

volunteers. Consultation regarding difficult client problems was occasional. In 1&1/2 years of service this occurred formally only four times; and in only one case was this about how to respond to a repeat impending call. In each instance, the volunteer was reminded of the principles which guided our operation.

Clients

What then of the clients? Data collection was minimal. Both the call for anonymity and the confidentiality of the volunteer-client relationship were explicitly protected. Data collection was minimized to avoid objectification (special attention to identified variables) at significant cost to trust and mutuality.

Rudimentary data relating to a small number of demographic variables - contact quantity, age, sex, status (married/single/other), etc., was collected. This proved valuable, not only to volunteers, but also to those who made inquiries about the nature of the organization's operations.

In the first year of operation, 70 clients contacted SA; about 50% of these in the age of 20 to 35, evenly divided as to sex, the largest group (40%) single, the next largest (10%) married. Data over time became a concrete referent which confirmed the organizational dedication of Suicides Anonymous. General statistics

enhanced the perception of Suicides Anonymous as an viable entity.

Data of all sorts serves to focus discussion on available information in the areas of suicide and suicide prevention. In this respect, our minimal collection offered little on which to base inference. But data not only feeds curiosity, it also stratifies functions internal to the system; adding status to those who collect, collate, and interpretation data. Because of this and the clearly delimited principles under which volunteers engaged clients, data was further de-emphasized going into the second year of operation.

Based on the modest data, roup, and individual discussions/sharing in conjunction with some general impressions, the following hypotheses emerged:

1)clients frequently verbalized fear and suspicion, not only of existing mental health services (psychiatrists, hospitals, welfare agencies, etc.), but of Suicides Anonymous as well. Primary fears were of involuntary detention (something several of our clients had already experienced), and the reporting of confidential information to significant others, e.g. parents. Despite overt dedication to non-coercion and confidentiality, significant mistrust of social agency function generalized to our organization.(25, Tabachnick)

2)clients utilized Suicides Anonymous both as an

alternative to and in addition to professional services. One client held extended conversations with a volunteer throughout a protracted convalescence in a mental hospital. He told us that he "could not talk freely with his psychiatrist." Another used us as a stop-gap measure while she was on the waiting list of the county mental health clinic.

3)Clients sometimes developed multiple relationships with several volunteers. Through the frequency of his calls, one client was known by voice to over 50 of the volunteer staff.

4|The large majority of clients contacted us only once or twice.

5)Unsolicited feedback from past clients was generally appreciative. One client felt, although she had been "helped," that this was a job for the family physician. Others maintained a deep-seated faith in professional services despite personal experiences to the contrary.

6)Individual volunteers were criticized as a) untrained; b) insufficiently directive; and c) too directive. Two clients were upset at the looseness of the organization itself, especially regarding bimonthly meetings.

Meetings and Morale

Bimonthly meetings included not only on discussion

of suicide, but an opportunity for those outside the volunteer force (e.g. clients, almost clients, interested observers) to get a feel for what was going on without requiring a commitment. Since meetings were open to everyone, there was some hesitancy upon the part of participants to engage in a sustained fashion in interpersonal explorations.

Among regular volunteers attending meetings (a minority), there was sentiment for a deeper kind of interpersonal involvement which expressed itself in informal social functions (e.g., parties given for other members) and verbal expressions for greater intimacy and less anonymity *within* the group.

After SA's inception, my own regard for diversified functions within the organizational changed. Initial interest was strong for both quasi-educational and group interpersonal explorations. Yet a clear sign on the part of most volunteers (reflected in comments and low bimonthly meeting attendance), suggested neither was central. Both elements diminished in the group context.

However, clientele and volunteers were encouraged to develop their own structures for filling these needs, utilizing internal resources and organizing others in separate projects. For example, if a group of Suicides Anonymous members wished to form a sensitivity group, this would be encouraged as a worthwhile project in its own right, but not organizationally sanctioned by

differentiation in internal group structure, i.e. those who are sensitivity group members vs. those who are not.

Congruent with the voluntary structure and lack of subsidiary goals, attendance at meetings was always a personal issue, never an organizational one. Meetings were held for those who wanted to attend, not for any other organizational purpose. Yet some volunteers still viewed the meetings as the central ingredient in the organizational stew; a point of view contrary to the focus of Suicides Anonymous on the development of interpersonal relationships as distinct from organizational connections.

At every possible level an attempt was made to relate the principles of self-determination and relation to the decision-making process in order to implement the evolution of individual responsibility within a context of great community concern. Structural simplicity was vital to affirm an individual's sense of participation in fashioning their own social reality. This task took us beyond the establishment of group loyalty to the core of inter-individual relation divested of the usual rules and roles that challenge the possibility of respect and mutuality.

Liberty and Responsibility

The paradox of establishing an organization devised to emancipate people from the devastating effects of

organization itself can not be ignored. (26, Nisbet) It is not self-evident why such an attempt might succeed rather than fail, either in its life-affirmative function, or in an attempt to introduce and maintain organization powerless over its membership and clients. Yet SA sought just that balance to serve its constituency.

Many organizations operate to usurp individual responsibility; to assert the necessity of organizational forms and schemata over that of individual decision. In so doing they frustrate dialogue by demanding unity and merger (group-think). This results in pseudo-relationships that promote non-mutuality, role distinctions, domination-subservient status. In contrast, for dialogue to succeed, each person must be "set at a distance," unique, worthwhile, and competent to engage.

For many persons, the "life of suicide" is a response to frustrated dialogue and dis-confirmatory blending; a downward spiral of numbing rejections the individual person.(27, Farber) Studies which establish the significance of antecedent loss within peer and other groups of suicidal individuals are confirmatory. (28, McCullock; 29, Murphy) Some argue,

"No therapeutic strategies will have any meaning if the calling person is allowed to take his life." (30, Haughton)

This coercive tactic ignores the instrument of

affirmative relationships, which is a dialogue of concern embedded in mutual respect. The fatal flaw of coercion is regarding the individual as a subordinate object for tactical manipulation; a dehumanizing role-to-role response identifiable as "Us-it." Detention strategies limit the possibility of healing the split between the subject and personally perceived world; they also create a deep intervening chasm between persons that promotes a final act of self-determination, the death leap.

Preventive interference is a superior-subordinate (master-slave) interaction. Suicide Prevention agencies exercise police-power (or in loco parentis) to pre-empt suicide. What is prevented is life process, a consideration or an "attempt" at suicide. But whereas suicide is final, suicide prevention is problematic. It can never be assumed that any efforts are more than temporarily successful.

In a coercive system, persons getting "in touch" with a preventing agency are bound by intimidation, threat, fraud, or physical restraint. Unless deliberately renounced, coercive power rests in all such professional agencies; whether staffed by volunteers, counselors, or social workers. Police, mental health officers, and psychiatrists complete the process. By "laying on hands," i.e. involuntary detention, they confirm the coercive "preventive"

process.

A new profession of "suicidology" is cause for alarm when the mask of "benevolent" intrusion is so powerfully disguised as "science." Psychiatry has already suffered discredit and distrust in the eyes of many persons considered suicidal. An alternative to coercion with the threat of incarceration is powerless discussion and suasion, i.e., relationship with focus and meaning.

Mutual Education

SA operates in an arena of problematic risk. From the beginning SA emphasized its fallibility and limitations in order to outline a legitimate scope of activity. Volunteers were encouraged to reach out and develop relationships in accord with their own needs as well as the clients. Rather than solution-driven motivational analysis and induction by expert manipulation of "what you really mean" "for your own good;" but discussion and response capable of dispute and rejection was encouraged.

Not all volunteers or clients acceded to this project in voluntary and mutual education. Some felt it inefficient and superfluous. One volunteer depicted our "seminar" meetings as "total waste - a crock of shit."

Evaluation

In our first year of operation, one client committed suicide. A young girl, of good intelligence, with a history of multiple attempts, hospitalizations, psychiatrists, firm resolve surrounded a core of prescient futility. She approached SA in conscious accord with our principles. Only on this basis did she willingly maintain contact, hoping for an answer where none had been before. There was none.

Increased social integration among some clients resulting in increased job stability. increased family integration, etc.. Assuming the value of such changes, the question of SA's contribution was not clear.

Problems in the evaluation of suicide prevention (or life-affirmation) services are notoriously difficult. (31, Kalman; 32, Devries; 33, Haughton; 34, Bagely). Organizational longevity is neither a necessary nor sufficient criterion of success. Our own social matrix is corrupt with businesses and agencies that refuse to die, and refuse to let live.

"Death is overcome on condition that the real actuality of life pass into these immortal and dead things..." (35, Brown)

Consistent with precepts of mutuality and equality, the ongoing process of self-determination was applied to the organization itself. As manifest leadership was progressively withdrawn, discussion ensued, with a renewal of commitment to the provision of this unique

service, and the formation of an esprit of perpetuation.

Whether the organization succeeds or fails in the face of the various fiscal, psychological, and psycho-social problems is presently uncertain. For the time being it continues on, not much changed from its inception. It is neither a discrete experiment nor a disembodied project to which a world trapped in metaphors subscribes. Rather, it continues as part of the life of those people who are its life, both clients and volunteers, in a renewed attempt to recognize and affirm both the common humanity and the unique individuality operative in all our behaviors and endeavors.

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Section II. Suicide and Social Control

A. Suicide

"There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy."

Myth of Sisyphus (1, Camus)

Suicide as concept presents us with some of our most perplexing questions as to the nature of man: determined or free; rational or driven by need; agent or programmed mechanism; purposeful or purposeless. As event, such puny categories hardly seem relevant when a cherished life stumbles towards or reaches out for oblivion or self-extinction.

Central to such queries is the problem of choice, a desire to initiate or refrain from action moved by belief and feeling. Beyond choice is the issue of freedom and intervention: the physical, mental, and social competence to effect, refrain, or deny choice.

Some speak as if choice were somehow made in a void, rather than the product of persuasion and pain, force and feeling. There is no void. "Rational man," intemperate or disembodied spirit, and transcendent or

numb soul alike operate within a personal context of feeling and thought.

A choice may be made with varying degrees of awareness (of conditions, alternatives, outcomes, etc.). To the extent that choice is made with more awareness, it equates with "rational" choice. But "irrational or "a-rational" choice is a choice non-the-less. It just presumes a lesser awareness.

For example, the man who choses the girl with the larger pupil diameter, the faint odor of musk, and the subtle pelvic thrust may be unaware of all these characteristics. Kinesics (body language), smells, etc. characteristically operate at preconscious levels. Do we then deny that a choice was made, merely because awareness was not present? No. But we may conclude we "free" choice was mitigated, that we were "drunk" (with love?), "hypnotized," seduced, transfixed; whatever convenience implies the loss of our freedom.

Awareness is necessary to thus necessary to "free" choice. Choice is a precondition, awareness an awakening to the possibility of freedom. Awareness is relevant after choice, to effect action. The paradox is that awareness may help or inhibit the choice. Less is sometimes better. The ability to gain the object of desire also depends upon more than choice and awareness. The agile or thoughtful person may bypass pitfalls that ensnare the slow and the dull. Yet

awareness may also dull the reflexes, and hesitation lose what strength might permit.

Hence freedom of choice depends also upon a congenial environment, a mesh of context, subject and object under conditions of awareness. The inimical culture that enjoins this mesh is an enemy of a free choice to live no less than the free choice to die.

Psychiatrists and laymen alike often suggest that a person is sane or insane, rational or irrational in virtue of a free choice for death. In accord with our analysis, this cannot be so. Rationality and sanity, are not relevant to free choice, but to choice itself, which may be coerced or forced. Awareness (subjective) and capacity (objective) are necessary conditions of freedom of choice. But they do not suffice for the following reasons:

Choices (whether free or no) may change slowly or rapidly, and choice itself is complicated by imputed meanings and public law and morals. Vengeful, militaristic, ruthless, indulgent, scheming, fastidious, and careless societies may encourage suicide. Closed and careful societies may fear behaviors outside duly shared and affirmed beliefs and values. At the root, denial of choice exemplifies intolerance of individuality rooted in fear of social disarray. The danger-fear equation is greatest within those closest to us; the family. In denying to our

siblings the ability to chose: their goodness, their sanity, their reason, their health, their insurmountable difference is cemented, and our shared possibility for freedom disowned.

A second tactic to disable choice (and stop suicide) restrains the physical capability of the agent/actor in a "controlled" environment. Physical restraint or its threat (coercion) is designed to block immediate risk - the risk of an insecure, unstable, unpredictable social action.

Finally, choice by constrained by removing the instruments for successful action. In the hospital/jail/prison this consists in securing potential weapons guns, knives, blankets, belts and shoelaces, drugs, alcohol, etc.

But prevention can not stop there. Both in and out of detention, society enjoins learning which may be dangerous. We refuse to provide an education in experience. We substitute shams that maintain a respectable distance: books, audio-visual aids, teachers who have not been there and would not go if they could. Secular privilege becomes sacred, e.g., driving, drinking, porn, fucking. Through the manipulation of privilege society protects its privileged by the denial of free choice to others.

Permitting free choice presents a sharp dilemma for social organization; balancing diverse interests,

resolving conflict peaceably, establishing examples and standards of principled behavior, maintaining cultural creativity and vitality.

Suicidal turbulence is typically a spin-off of conflict between individual and sub-culture. It represents the frustration of personal interests. Intervenors may hasten or proscribe death. Society may ritually chant: "It is not in your 'best interest' to kill yourself." Individuals may claim a higher moral ground: "I can do what I chose as long as it harms no other." Both are hypocritical. Rule-makers attach moral superiority to physical compunction. Rule-breakers deny social harm where only private interests are at stake. Both society and the individual deny the obvious - a simple conflict of interest. Both employ the tactic of defining (or ignoring) the other's interests.

But in some circumstances, the public interest is congruent with the personal aspiration. Nations in conflict instruct and reward both individual and mass "patriotic" suicide (e.g., suicide missions, harikari, kamikaze pilots). Individuals may kill themselves to maintain family or gain peer repute, "accidentally" suicide to confer insurance benefits on relatives; or seek euthanasia (mercy killing) for relief from pain.

"Mass" and "double" suicides (mutual death-pacts) represent an instance of suicide with congruent social interests. The method of induction may be coercive or

free, determined by leaders, or left to one or the other party. (2, Meerloo)

In euthanasia, where death is inflicted by another, it seems paradoxical to term it "suicide." But in the sense of suicide we have been exploring, i.e., suicide as the choice of death, such pacts reveal the mutual relationships and dependencies often concealed or implicit in other forms of suicide.

Perhaps one-third of all suicides in America are the result of drugs prescribed by physicians.(3, Brophy) Must we thereby infer that the physician murdered the patient? Suicide, like homicide, is both empirically tied to the conditions surrounding the act and conceptually tied to the interpretation of events. Settling responsibility is a process dependent upon both fact and interpretation. It is a social process, which when carried out under agreed upon standards, serves to remove or limit immediate dispute.

Unlike the ascriptions of "guilt" or "homicide" the lack of a procedure for ascertaining responsibility (culpability) in the case of attempted or possible suicide reveals much about the confusion in which the term "suicide" is shrouded. The sociology of suicide, i.e., the events, values, and cultures sustaining the acts and attempts make complex the process of ethical ascription. The interdependence of individual and milieu defies a simple isolated conception of human

behavior. The delineation of "social meanings" (4, Douglas) for suicide makes attributions of individual responsibility misleading and anachronistic.

Confusion of fact and interpretation can be found in the comments of entertainer Art Linkletter following his daughter's death. (5, Linkletter) Linkletter said,

"It wasn't suicide because she wasn't herself."

"...although her death was self-destruction, it wasn't suicide, it was more than that."

"It was murder. She was murdered by the people who manufacture and sell LSD."

He later summed up his thoughts for a special Presidential White-House conference on the drug problem:

"my beautiful 20 year-old daughter leaped to her death from her apartment, while in a depressed suicidal frame of mind, in a panic believing she was losing her mind from recurring bad trips as a result of LSD experiments 6 months before." (6, Linkletter)

The disturbing circumstances of this death must be acknowledged, as well as Linkletter's impeccable logic. If a person is not "herself," she can not kill herself. Therefore someone else/or something killed her. But it is dubious on both ethical and empirical grounds. If a person self-destructs while under the influence of a drug/person/medical condition, who (if anyone) is responsible? Has she been murdered? If a person in a panic or state of disorientation steps from a third-floor apartment ledge is that an accident? Murder? Suicide?

This type of confusion occurs because "suicide" is not merely a description of an act, but a social interpretation involving hidden values and social standards. Parents or close relatives who deny the interpretation of suicide may seek relief from complicity or guilt. A suicide stigmatizes/dramatizes close associations.

Suggestions of "panic," "not herself," "losing her mind," stuff the person in a psychiatric box. An illicit street drug, partially absolves the professional. But many drugs prescribed by physicians also carry mortal risk.

Why is this posturing necessary? Is it more than social scapegoating? The answer is a qualified "yes." Our culture cushions shock with mutual blame, and expedites social controls that mitigate guilt-provoking conflicts. We develop consensus through compulsory education, adaptation through work and taxes, and conformity through law.

Failures of socialization are processed in many fora: social workers, courts, hospitals. At this time, humanitarian instinct and faith in professionals tend towards the latter. The result has been intolerance fomented by the social manipulation of prejudice against deviant behavior. We opt for a pseudo-medical instrument (psychiatry) to coercively contain social turbulence under the guise of personal mental illness.

A significant value commitment to conformity has been

established as a social ideal. The conflict between man and society is clearly in favor of society. Journals of "conflict resolution" beg the most important question - when should conflict be resolved? When and under what circumstances is prevention desirable? From whose point of view? What are the competing interests involved?

When these most fundamental queries have been satisfactorily examined, we may reasonably and responsibly face the next most important question. How may the task we have agreed upon be ethically accomplished?

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B. Prevention

"We must shun uniformity of surroundings as much as absolute conformity in behavior and make instead a deliberate effort to create as many diversified environments as possible...Insofar as as possible, the duplication of uniformity must yield to the organization of diversity." (1, Dubois)

It is base error to imagine that success in preventing suicide depends upon the structural features of any one agency design. Vague definitions and studious ignorance of ethical issues may actually promote diverse agencies of social action and social control.

Strategies of prevention encompass all known modes of socialization in their aim to reduce the incidence and prevalence associated with the unwanted behavior. Tactics range from a) promotion, propaganda, and education to b) coercion, isolation, stigmatization; thence to c) management, treatment, and rehabilitation. These stages correspond to primary, secondary, and tertiary prevention respectively.(2, Whittington)

Primary prevention seeks to reduce incidence and prevalence rates. Its main focus is the reshaping of social attitudes. This is primarily an educative role. Secondary prevention is crisis intervention; an attempt to reduce immediate disability. It therefore involves identification and isolation of the undesirable carrier of the 'disorder.' By social dynamic this typically entails

both classification/separation accompanied by either overt or covert stigmatization and degradation. These elements facilitate the second stage of prevention which is restraint of liberty. Secondary prevention is always coercive, the threat of or enforced limitation of free choice. Finally, tertiary prevention seeks to cleanse, extinguish, or remedy the undesirable condition. This it does through any available modality; including "treatment" and "rehabilitation."

As Stengel puts it, suicide prophylaxis ideally starts at birth or perhaps earlier. It aims to

> "... eliminate or reduce all factors which tend to increase the incidence of suicidal acts and to strengthen all those which tend to reduce it." (3, Stengel)

Given the range and scope of contemporary notions of suicide (4, Menninger), such prophylaxis could only come about through extensive programs of social oppression. Virtually all acts of exploration and risk-taking behavior would be proscribed.

In fact, suicide prevention agencies in the United States have evolved in two directions: (A) as disposition services; and (B) as crisis intervention services. Triage or disposing of an individual is the major task facing most agencies of suicide prevention. Like other persons or agencies (parents, friends, teachers, physicians, etc.) to which the suicidal individual may have appealed, prevention agencies engage in a sophisticated game of buck-passing. If individuals bear minimal stigmata

(publicly endorsed signs or symptoms) of mental illness, they are referred to a mental health clinic, psychologist, or psychiatrist. If classified as 'highly lethal' (actuarial estimate that self-destructive attempt may succeed), the police may be called with transport to county mental health officer, the hospital emergency room, or community crisis service. When suicide prevention agencies are integrated or subsidiary to hospital or mental health facilities, they invariably perceive their primary role as a crucial link in the disposition chain,

> "...notifying others, obtaining consultations, alerting those concerned with the potentially suicidal person including relative and friends, getting the person to a sanctuary in a psychiatric ward or hospital. " (5, Schneidman)

The euphemisms of 'getting to' and 'sanctuary' obfuscate and cloak the threat of police power and civil commitment. For these agencies, prevention implies the assumption of authority over another person's life. The legitimacy of this presumption is fundamental to most agencies adopting the prevention model.

Comments in the prestigious American Journal of Psychiatry flesh out the details: (6, Schein and Stone)

> "...the therapist must take pains to make clear to the patient that he, the therapist, considers suicide to be a maladaptive action, irreversibly counter to the patient's sane interests and goals; that he, the therapist will do everything he can to prevent it and that the potential for such an action arises from the patient's illness.

"The therapist must directly label all suicidal thought as crucial to any psychotherapeutic endeavor...If the issues can thus be objectified, the therapist can avoid the potential danger of the patient's misperceiving the therapist's attitude as one of moral condemnation."

"The therapist must insist that patient and physician - together - communicate the suicidal potential to important figures in the environment, both professional and family...suicidal intent must not be part of therapeutic confidentiality."

"The therapist must be prepared to step in with hospitalization, with security measures, and with medication...Moreover, electroconvulsive therapy should be considered, even when there is an apparent lightening of mood...this is particularly pertinent since there are data which indicate that there is an increased risk of suicide within three to six months after hospital discharge, even after electroconvulsive treatment."

The overbearing certainty which promotes these instruments of stigmatization, derogation, prophecy, penal authority, drugs, and electro-convulsions, befits a genre that eschews moral responsibility in the name of medical science. It is the clearest renunciation of individual liberty, and the strongest self-authorization of power within the preventive mental health ranks.

In a brief 1967 rejected communication to JAMA I examined a basic conflict between individuals confronting authorities and agencies in terms of jurisdictional preemption. ((7, Many) Whereas jurisdiction may be legitimized by legislative and judicial process (8, Dawson); it may also come about through default or

boisterous claim often masked by labels that have already gained acceptance. The creepy 'health' invasion into all realms of social interaction is a prominent feature of civil degradation. (9, Szasz) "Getting the person to a sanctuary," i.e., forced detention in a psychiatric unit or general hospital is a smiley subterfuge masking professional dedication to social control.

Masked Coercion - Psychiatry's Secret Weapon

A recent Syracuse Sunday section headline loudly (and falsely) proclaims an American preventive dilemma: "Shout for Psychiatrist or Cop?" As the author puts it,

"The know-nothings, or forces of repression, aren't torn between psychiatrist and cops; they favor the cops." (10, Lisagor)

This is a false dilemma. Psychiatry has police power. And uses it. Within ranks there is debate over tactics and territory: re-education, positive reinforcement, psychodynamic therapy; categories loosely corresponding to counselor/social workers, psychologists, and psychiatrists respectively. But with rare exception, "experts" are manifestly dumb where civil status boundaries are breached and met with professional pretense and intimidation.

The general public tangibly subscribes to soft "for your benefit" coercion. After all, it is groomed to accept lawful government and workplace coercion: teachers, educators, bosses, and other-wise. Males are however wary of psychiatric services (bad for repute, job advancement, and individual indulgence), while commending it to a low-status constituency - women, children, adolescents, geriatrics, unemployed, students, alcoholics, racial minorities, radicals, and other misfits.

Professional jurisdiction disputes are seldom open

and public, with the possible exception of the legal profession - fortified by a tradition of scepticism and adversary procedure. Within the recent past open criticism and confrontation has emerged among students (11, Lipset) and social workers (12, Wineman).

Within psychiatry, distinctions between individual and social interests are generally glossed in extended psychodynamic formulations, with critiques of organization ethics virtually extinct. With entrenched faculties dependent on lustrous local treasures (well-connected faculty, academic publication success) and government largess, debate largely centers on three intervention dimensions: a) medical (biological, chemical, surgical) b)psychological (counseling, supportive, rational (cognitive), emotive, behavioral); and c)social (individual, family, group, milieu).

All such embedded psychiatric debates take place under the rubric of "medicine," and even the most elegant and boisterous critics trade on their MD (medical doctor) credentialed state-monopoly for expert practice. Professional dispensations (procedures, prescriptions, internment) few organization alternatives have emerged.

Medicine's police power is most prominent in emergency medicine, psychiatry, and public health. The police regulate licensed premises; ticket for minor violations; track and arrest for major crime, and enforce general standards in disparate communities and subcultures

in their broad mandate to "keep the peace."(13, Bittner) At their discretion, often based on an exchange with the politically appointed Director of Community Services (DCS), police deliver prior and presumptive "patients" to emergency rooms, where they are eyeballed/drugged ("quieted down") by the ER Doc, examined by a psychiatric nurse, social worker, or "Crisis Management Team," unit and "admitting" psychiatrist notified, and either discharged (with meds/clinic "follow-up") or interred. The threat of commitment the "next time" is inherent, and each ER "visit" (especially at night) or prior psychiatric diagnosis increases the likelihood of confinement.

The police rationale is primary and secondary prevention, i.e, minimizing the possibility of imminent social crisis while promoting social competence, laudable goals shared with institutional psychiatry and suicidology in particular. At this table of prevention, psychiatry feeds on both police power and *parens patriae*, state delegated powers effectually authorizing a conditional determination of social competence or its obverse, incapacitation.

"Social competence can be gauged in terms of the ability of persons to participate effectively in the legitimate activity of their society."(14, Gladwin)

Szasz highlights a prominent but little noticed institutional posture that impedes awareness and underlies this devolved parental authority:

"...in his relation to the student as an individual,

the college psychiatrist refuses to make contracts which would make his behavior predictable, he governed himself instead by the principle of therapeutic indiscretion, according to which he may do virtually anything to the student under the guise of acting In his 'best interests.'" (15, Szasz)

This standard of discretionary subjugation by therapeutic personnel undermines citizen civil rights premised upon self-regulating non-criminal conduct in accord with published law.[2]

Coercion - Preventing Voluntary Motor Behavior

Both the police and the psychiatrist engage in promoting and regulating social adaptation, as defined by custom and law. Both professions are permitted coercive suasion including the threat of detention and detention or commitment where less rigorous controls do not avail. Although coercive force generally suggests the blocking of voluntary motor (neuromuscular) behavior, the threat of force by fraud, suggestion, intimidation or other means is also coercive.

In contrast, primary prevention suggests proximate restraint. Police may effect this preventive measure with take-downs, handcuffs, blows, shots, and detention and

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[2] ***The Body of Liberties of 1641***, **Haskins, "Law and Liberty in Early Massachusetts," (NY: MacMillan, 1960)pp.129-132**

jail. The psychiatrist accomplishes the same through the drugs, restraints, and and hospital detention. Penal and therapeutic efforts are not credibly distinguishable by the nominal civil vs. criminal statutory authority or the setting under which intimidation and/or restraint is exercised.

"...no resort to subtlety can refute the fact that the power to imprison is a criminal sanction. To view otherwise is self-delusion."(16, Goldstein and Katz)

The role convergence of police and institutional psychiatrists does not deny their differing constituencies, their sometimes competitive turf wars, or their vocal fealty to distinct traditions. Psychiatry appears more devious by psychological-behavioral ("brain washing") and biological "chemical straightjacket" (drugs) techniques. This may be attributed to a professional distaste for involvement in overt aggression. A significant historical tradition promotes the social value of a state agency where, as Foucault puts it, "the *caduceus* keeps the lid on the 'container of unreason." (17, Foucault)

Suicide prevention agencies are not necessarily united in how to exercise coercive force. A suicide prevention team from Corpus Christi, Texas, trains "face-to-face" volunteers in the "manly arts" of self-defense and unloading guns. (18, Medical World News) While this may be exceptional, the threat or use of police power is widely espoused, although often disguised in the rhetoric

of benevolent necessity. When the chips are down, it is not merely "desirable" to break confidence, it is not "possible" to do otherwise.

"The traditional idea of not breaking confidence is splendid, but it is neither desirable nor possible to uphold when the patient is so sick that it threatens his life." (19, Solomon)

Therapeutic "necessity" also drove the systematic extermination of 275,000 "mental patients" in a program sponsored, planned and organized by eminent German psychiatrists and pediatricians during World War II. The lawful mass extermination of persons neither dying nor in pain (other than by government decree) is durable testimony to medical practice in the service of social policy. (20, Roche Report)

Suicide of conscience is one clear effect of agencies coopting the most profound life-decisions of individuals. This deterrent to personal initiative and responsibility is promulgated by white coats with a state authorized MD registration on the wall. Exercise of coercive force in restraint of free choice in the absence of imminent harm to others is a profound contravention of civil society. It cannot be concealed in the metaphor of "treatment" under coercive threat or by preventive detention termed "civil commitment" with its attack on the liberty of citizens under the rule of law.

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C. Suicide Prevention

"The very establishment of an NIMH (National Institute of Mental Health) Center for Studies of Suicide Prevention by the Director of NIMH is an important and historical event in our crusade against these tragic deaths and cannot but have a beneficial impact on suicide-prevention activities throughout the country. By virtue of its very existence it will give impetus and permissiveness to suicide prevention." (1, Schneidman)

"For philistinism thinks it is in control of possibility, it thinks that when it has decoyed this prodigious elasticity into the field of probability or into the mad house it holds it a prisoner; it carries possibility around like a prisoner in the cage of the probable, shows it off, imagines itself to be the master..."(2, Kierkegaard)

The transformation of Suicide Prevention into big business is a recent phenomenon. Prior to 1958 there were only three such centers in all the United States.(3, Schneidman) The inception of the Los Angeles Suicide Prevention Center in 1958, financed by federal grant, initiated a decade of rapid expansion. (4, Farberow) Recent estimates place the number of centers at close to one-hundred. The impact of this expansion has yet to be felt, either in terms of reduction in the suicide rate, or in altering basic attitudes. (5, Bagely; 6, Haughton) In view of the paucity of data and the lack of consensus with respect to the nature of the problem, it is troubling that several of the basic assumptions and values of this approach have received

only nominal attention.(7, Resnik; 8, Brunt)

Planned growth assumptions are detailed in a 1968 NIMH (National Institutes of Mental Health) Bulletin of Suicidology: (9, Schneidman)

1. Prodromal clues exist in almost every case of suicide and suicide prevention depends upon their recognition.

2. Individuals who want to kill themselves want to have their deaths prevented.

3. Suicidal behaviors stem from a sense of isolation and from feelings of some Intolerable emotion.

4. Suicide prevention depends on active and potentially coercive intervention.

5. Helping personnel have a responsibility to prevent suicide and can have no excuses for holding back on life-saving measures.

6. In almost every case of suicide, there are hints of the act to come.

"Prodromal clues" and "hints of the act to come" are (almost) invariably present; and "prevention" (almost) always "depends on their recognition," For events with a low probability of occurrence (generally on the order of 20 suicides per 100,000 in population), hints are a particularly poor in making any inference regarding intent. To put it another way, there are far to many hints in the general population of persons that neither attempt

nor complete suicide. Even a history of attempted suicide is a remarkably poor predictor (by itself) of a future completed suicide.

Furthermore, even if clues raise the probability of a nasty event in general, what is the significance of that clue in a specific individual? If a patient describes a dream in which self-mutilation is prominent, this may qualify as a clue to suicide in a small proportion of patients. It is only a "hint" (in retrospect) if the patient goes on to threaten, attempt, or commit suicide.

Since clues to suicide occur at a lively rate among non-suicidal individuals, they might justifiably be termed "hints" of non-suicide. Some specific hints may carry greater weight, for example verbal or written threats in a context of defeat, pain, and futility are correlated with completed suicide. (10, Wilkins) Yet even here, it is uncertain at what frequency similar communications take place among non-suicidal populations. Suicide threats, communications, and notes must be decoded, interpreted, and placed in context. Who does this is of singular import.

Schneidman estimates that 75% of persons who commit suicide are found to have visited a physician 'within months' of taking their lives. (11, Scheidman) Yet what percentage of the general population visits a physician "within months?" Or those suffering from physical illness? Or impoverished, hypochondriacal, or medically insured,

etc.?

The significance, indeed the existence of "prodromal clues" has yet to be sustained by controlled study. Current "evidence" for the existence of the prodromal clue is largely based on the 'psychological autopsy.' Originally devised for the purpose of examining the context of suicide, it has become a tool for interpretation of 'intentionality' and assessment of perspective towards one's own death.

In medicine proper, an autopsy manifests itself as the final court of evidentiary appeal, permitting an etiologic (causal) interpretation of disease or death. Yet even a physical autopsy may disclose previously unknown pathology or pathology for which a patient was treated but from which the patient did not die. Such a person may be treated for a cancer, but died of crush injuries in a car accident.

In contrast with a medical autopsy, a psychological autopsy consist of interviews with witnesses or relatives termed 'survivors,' not with post-death mental status exam (whatever that might be). This is no autopsy, but a topsy-turvy

"attempt to reconstruct the intention of the deceased in relation to death." (13, Schneidman)

The assumption that death is causally related to a prior mental state, rather than a physical condition problematic even in medical autopsy, is a psychological

fashion show, more revealing in what it covers-up than what it covers.

Prodrome and Prevention

Even if prodromal clues do exist (a proposition awaiting clarification and controlled study), the use of such purported hints begs for examination. What or whose interests are served?

"Currently the major bottleneck in suicide prevention is not remediation, for there are fairly well-known and effective treatment procedures for many types of suicidal states; rather it is in diagnosis and identification." (14, Schneidman)

My own contact with patients (general hospital, state psychiatric hospital, V.A. hospital) suggests that suicidal communication is extensive and identification of "high lethality" ccommon (15, Solomon), even with minimal professional rapport. The difficult question is "what to do?" where the scope of medical authority is revealed at the interface of voluntary intervention and involuntary detention.

Intentions and Interference

"individuals who are intent on killing themselves still wish very much to be rescued or to have their deaths prevented..." (Schneidman)

Schneidman (and others) 'cry for help' hypothesis is ostensibly drawn from samples of communications by those who contemplate, attempt, or later complete suicide.(16, Simon) However, its resemblance and debt to the psychoanalytic dream and "death wish" theory is considerable. Such interpretive bias especially serves those anxious or determined to "help" as it justifies intrusive intervention.

Ambivalence might better characterize the self-termination predisposition.(17, Farber) Such mental turbulence and behavioral approach-avoidance predicts ups and downs in intention, mood flip-flops, and start-stops in suicidal disposition. However, since ambivalence accounts for contradictory and mutually exclusive outcomes (i.e., self-destruction or non-destruction), it exemplifies the incoherence of 'anomalous explanation'(18, Angel) which is a metaphysical or pre-scientific conceptual rendering which loses precision as it increases in generality. (19, Hartmann)

Theories of unconscious intention, ambivalence, and cry for help play a significant role in the ideology of suicide prevention.

"...the underlying assumption of our duty obviously

is that the endangered [person] desires help and rescue, and, if able to do so calls out for help" (20, Rudzinski)

These constructs justify, rationalize and legitimize the interference of agencies with the volition of the individual. They are instrumental in the politics of behavioral management. The alternative is to demonstrate an overriding social benefit which legitimizes lawful intervention.

Such twofold approaches (psychological constructs plus prohibitory laws) are not mutually exclusive. Yet the "'social necessity' paradigm, through recognizing division of interests and diversity of goals, at least sustains the possibility of an informed populace, acting in its own interests. On the other hand, the alchemical 'wish projection' adherents claim 'benevolent' intervention through expert preemption, reducing the individual to subjugation, converting dross to gold.

Mortal Depression vs. Morbid Oppression

"Practically all suicidal behaviors stem from a sense of isolation and from feelings of some intolerable emotions on the part of the victim." (Schneidman)

There is striking evidence to the contrary. The suicide of Ellen West occurred during her realization of marked subjective relief and objective heightened

affect.(21, Binswanger) This observation parallels that first made by E. Bleuler in 1924 and repeatedly corroborated that suicide most frequently occurs in a period of apparent remission of depression.(22, Lesse)

Although many psychiatrists now assert that suicide is part of the "natural" mortality of depression (23, Silverman), a 1933 examination of 1000 consecutive attempted suicides found no association between depressive illness and suicide. (24, Lendrum) Only 34 years later (1967) 50% of all suicides are considered cases of depressive illness. (25, Murphy) Is this a new "silent majority" or a subsidiary process where depression follows social rejection and alienation?

As with 'prodrome' and 'ambivalence,' the utility of professional rhetoric is clear. Such associations beget a new client/patient in a fetal posture, legitimizing "treatment." Pseudo-scientific medical ascriptions are politically correct interpretations of overt conduct and communication and service professional turf expansion.

Forthright or Forthwrong?

"Suicide prevention depends on the active and forthright behavior of the potential rescuer...Suicide prevention is like fire prevention...when the minimal signs of possible fire or suicide are seen then there are no excuses for holding back on lifesaving measures." (Schneidman)

All of us play both active and passive roles in the

prevention of our own suicide. Avoiding the highways on Labor Day weekend, draft-dodging and pedestrian traffic dodging, are techniques in the avoidance of self-induced destruction.

"The analysis of the agents who intervened in the suicidal act and thus secured or helped in the patient's survival, shows that frequently it is the suicidal individual himself who intervenes." (26, Stengle)

If this is the case then we must suspect that the potential rescuer is serving his own needs and not those of the client when he makes his (rescuer) behavior the focus of suicide prevention.

The specialist claims privileged understanding will enable "general understanding."

"Prodromal clues for fire prevention have become an acceptable part of our common sense folk knowledge; we must also make the clues for suicide a part of our general knowledge," (27, Schneidman)

An analogy is neither true nor false. But it may reveal hidden connections, as with falling apples and full-moon tides. Scientific analogies stand or fall in terms of their explanatory or predictive power. (28, Dreistadt) In the world of shamans and politics, analogies are rhetorical devices used to captivate and persuade audiences. (29, Burke)

Edwin J. Holman, director of the Medical Ethics Dept. of the American Medical Association, clarifies the professional dilemma:

"There is no law which says the physician must take complete charge of the patient...or substitute his wish, his will, or his judgment for that of the patient..." (30, Holman)

Suicide is not a medical disease or public health issue, but a lawful personal interest with social ramifications. It has no place in an involuntary system of professional interference which presumes authority (like the secret police or CIA) to place violators in preventive detention. What are the features of such an expert system?

"First, it is self-regulatory: that is, there are sanctions, there are rules, there are norms which govern its behavior. Secondly, it is a system which the stranger, the outsider, even the police are relatively reluctant to enter. However, because it is a system which has built in authority, it contains both obligations to intervene and powers with which to make such intervention possible." (31, Gussman)

A rationalized professional claims of eminent domain is simply a political exhortation and moral prescription. A signal difference between fire prevention and suicide prevention is contextual. Fires are mostly lawfully set in factories (furnaces), homes (stoves), and at the tip of a cigarette.

Individual suicide, although lawful, is generally subject to religious and ethical proscription. A fraudulent appeal to expert "specialized knowledge" asserts extraordinary authority over the life and

liberty of fellow humans. It is a claim unworthy of science.

The rapid growth of suicide prevention agencies throughout the U.S. makes a closer look at basic assumptions in the medical mold imperative. The values of suicidology's medical field commander Edwin Schneidman come down to claims of (a) superior knowledge about cause and diagnosis, and (b) necessary preventive detention.

These claims represent a deliberate confusion of substantive and normative issues, fact versus value. Statistical manipulation of infrequent events yields pseudo-scientific 'high lethality.' Key rhetorical terms for psychiatric purposes are prodromal clues, unconscious intentions, cry -for-help, ambivalence, isolation, and depression.

But even accurate and reliable medical labels (signs, symptoms, diagnosis) and dependable actuarial tables are an insufficient basis for the sacrifice of individual civil liberty. Cancer or diabetes can not justify coerced treatment. Wherever 'civil' commitment requires mental illness in additional to imminent suicidal risk, psychiatrists can be expected to don the latest fashion in cultural credulity, *suicidology*. It is certainly good for business.

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D.Prevention Alternatives

1)The Medical Model: Unsafe at Any Speed?

The growth and influence of psychoanalysis within academic psychiatry portended an expansive linking of distress and psychiatric diagnosis to broader issues of public deviance. With respect to suicide prevention, the marriage of psychiatry to public health also constitutes a pre-emptive strike against other professionals, namely social workers and sociologists, who bring their own expertise to this transgression, but have limited coercive authority. Suicide is a social problem ripe for psychiatric conquest. (1, Angrist)

Opposition to the medicalization of suicide comes from several sides. (2, Sabshin) Medical emergency specialists (ER docs) emphasize deficiencies in the administration and delivery of services. A similar but much broader public health perspective makes prevention paramount. The traditional public health model centers its immediate attention on the patient. Its tools are isolation, quarantine, and individual therapy. But a newer subdivision, community mental health, would diffuse traditional roles and intervene at all points before, during, and after (mental) hospitalization. Its therapeutic focus is mileau reconstruction.

Some psychiatrists, psychologists, and sociologists take strong issue with the public-health/community mental

health model:

"...opposition to community mental health exists among a number of behavior scientists who view community mental health as a medical intrusion into a variety of social and/or learning problems." (3, Angrist)

A small but vigorous "problems in living" coalition of psychiatrists, lawyers, and individuals present a fundamental concern with civil liberties intrusions and denial of open and mutual decision making. (4, Szasz)

By replacing personal accountability with expert therapeutic determinism, stigmatized behavior is removed from public view and transferred to the professional office desk or hospital. But the metaphor of illness applied to social deviance provides minimal benefit with large associated risk. (5, Danzger) The difficulties are abundant. Here is one application (from an associate clinical professor of psychiatry) showing that homosexuals are "sick":

"In medicine we are taught that sickness is the failure of function. For example, a gall bladder is pathological precisely when it ceases to function or its functioning is impaired. A human being is sick when he fails to function in his appropriate gender identity, which is appropriate to his anatomy." (6, Socarides)

The good doctor succeeds in confusing physiological anatomical, psychological, and social constructs. He equates functional impairment with "sickness." What of accidents? If an auto runs over your foot, how do you feel about walking? It is a formidable misrepresentation

to ignore the context in the ascription of psycho-social malfunction. Dr. Socarides, in his appeal to "appropriate gender identity" and "appropriate to his anatomy" lets the old value cat out of the pseudo-scientific bag.

What is "appropriate" in the realm of human behavior is not easily resolved. Given a limited context and a defined set of goals we may profitably discuss malfunction, maladaptation, or psycho-social pathology. But where norms are obfuscated or invisible, and/or the setting and values ignored, such a discussion is gossip with the implicit goal of social control.

The strategy of control is not restricted to the medical model. A scientific model by itself cannot legitimize control of fellow humans. "What man can do" (Ethenics, environmental engineering) "he must do" (Ephenios, human engineering)? What values does this entail?. (7,Dobzhansky)

Can we ascribe to particular models defects which may be generic? Objections to current public health services chiefly address a traditional fractionated medical model. (8, Turner) Alternative frames of reference, such as "General Adaptation" theory (9, Spencer), or "Crisis Resolution" (10, Cumming) take little account of social imbalance in deeply established social and political structures to which they adapt.

"Integrative health services" amplify pre-existing inequality and loss of privacy. For example, as part of

the New York State package of mental patient rehabilitation, our community mental health center (Syracuse Psychiatric Hospital) was expected to first provide the State Employment Bureau with data on patients relevant to the possibility of their holding down jobs; second to alert the Department of Motor Vehicles with respect to their ability to drive a car; and third file information with the Federal Government for Social Security determinations.

The call for "integrated services" met Suicides Anonymous head on. The local Mental Health Association attempted to bring SA into the fold under the cloak of a political mandate for such services. But any agency which dominates a field calls for integration of services. One tactic divorces management from workers, and workers from clients.

"Eventually the mental health professions become grossly alienated from the human realities of the very clients they purport to help, and the professions soon achieve the status of being irrelevant." (11, Graziano)

Models help to identify different values implicit in different attempts to solve problems. But the emphasis on portable seamless models, i.e., modules, inevitably elevates managers to the first rank, and expert and specialists to the highest status. It enhances the distance between the service, the workers, and those served. Intensive and extensive training increase interpersonal distance. Training of personnel may thus

decrease capacity to perform tasks dependent upon relationship development. (12, Carkhuff)

Models are heavily dependent upon classification and triage. The down-side of labeling includes stigmatization rewards dependency and obedience. These adverse effects are not unique to the medical model, but of integrative systems which value efficiently rationed technology and scientific mastery.

Models utilizing concepts of residual deviance (13, Schaff), social ineptitude (14, Goode), and eclectic grab gab-bags encounter similar risks. Professional superiority needs subordinate clientle. Thus difficulties adherent to particular models, may be inherent in the modular approach, i.e., the specification of a transferable mode of intervention based upon privileged knowledge and expert opinion. This in turn represents a democratic dilemma in the application of expertise, where technology and science assume roles previously relegated to religion and morality.

2) Cooperative Community

"But life is never certain, never predictable, never controllable; in order to make life controllable it must be transformed into death...the question is whether the principles of life are subordinated to those of mechanization, or whether the principles of life are the dominant ones." (15, Fromm)

The tribute and trial of 'Community Mental Health' rests in its implied breadth and width. But to what does

it refer? The Community Mental Health movement combines specialism and bureaucracy in order to secure order, control, and uniformity. Its battle cry is "integrated services!" For these purposes, the recognition of legitimate difference and justified conflict is marginal and dubious.

The value of social conflict is not accounted by current medical, social, or educational models. Internal modifications by personnel (nay-sayers, whistle-blowers) effect little structural change at great risk to status and employment. Solutions to systemic rigidity require the capacity and will to adaptively deal with changing environments and unstable system states. (16, Boguslaw)

Administrators often see themselves as powerless to effect change. A report noting the essential sanity of Adolph Eichman concludes he was the prototype of administrative idealism 'just doing his job.' (17, Merton) In the "Ethic of Ultimate Ends" we hear that the "Christian does rightly and leaves the result with the Lord." (18, Weber) The bureaucracies of technocracy are in awe of superior knowledge and numb to its ethical arrogance.

It is not just the will, but the capability to innovate that is lacking.

"It is inherent in centralization that power-lessness spreads from the bottom to the top." (19, Goodman)

"...the professional bureaucrat (administrator) is chained to his activity by his entire material and ideal

existence. In the great majority of cases, he is only a single cog in an ever moving mechanism which prescribes to him as essentially fixed route of march. The official is entrusted with specialized tasks and normally the mechanism cannot be put into motion or arrested by him, but only from the very top." (20, Weber)

But where is the top? Everybody knows there is a top, but nobody can find it. When controversy developed over 'civilian' control of policy-planning and staff review at Lincoln Hospital, Dr. Peck, director of Mental Health Services famously observed:

"When there's a foot planted in the seat of my trousers to kick me out of here, I'll know we've succeeded. It will mean that the people want to take over the running of their own community. And that's the way it should be." (21, Hospital Tribune)

Peck actually agreed to a board of review on which both professionals and non-professionals would be represented. Shortly thereafter, counsel for ubermaster Yeshiva University stated that such powers could not be delegated. Frustrated lay Puerto Rican and Black mental health workers allied with some sympathetic professional to assume operation of the service. Within several weeks the Department of Psychiatry of Albert Einstein College of Medicine of Yeshiva University arrested 23 staff members, suspended 70, and threatened supporting physicians and other professionals with malpractice proceedings and license revocation.(22, Harper)

The will for innovative change was not lacking at

Lincoln Hospital, either on the part of administrators or those representing the community. But the capability for change within the system was undermined by management which severed administrative responsibility from administrative authority in order to perpetuate an integrative service technocracy - The College of Medicine, The University, and (perhaps) the NIMH (National Institute of Mental Health) which financed the project through a staff grant.

In instances such as this, the will to legitimate change is zapped by a diffusion/confusion of authority, i.e., an authority which contravenes local control but disavows decision making responsibility.

"We win, as a result of this fragmenting of the field of perception and the breaking of movement into static bits, a power of applied knowledge and technology unrivaled in human history. The price we pay is existing personally and socially in a state of almost total subliminal awareness..." (23, Carpenter)

Subliminal awareness may underlie blindness to conflicts of interests and competing values within areas of legitimate concern. But innovation and problem solving at both the level of individual and community require developed awareness, participation, and resolve to redesign success by re-examination of means and ends.

This is the crisis of democratic community, a issue of citizen control and citizen responsibility. In local communities of interest, such as the therapeutic community where individual lives are units of concern,

the emerging problem is mitigating bureaucratic and technological hegemony. Beyond this, the therapeutic complex aggregates mass value at the expense of local and individual interests. This arrogance of power is of crucial import to democracy based upon knowing individual participation.

3) State-of-Art and Artful State Therapeutics

Critics of contemporary society often target the gap between pure and the applied science. But a greater threat lies in their integration under conditions of coercive authority. Attempts to advance the marriage of science and society generally take two forms: a)consensus building (government education, controlled media); and b) imposition of coercive authority (police, mental health officers). (24, Darhandor) Society generally opts for coercion where political power is minimally distributed, for coercion is then easily applied and accounted in administrative terms. The development of broader consensus presupposes consensus among the sources of authority, and tends to utilize coercive legal and extralegal tactics in its advancement.(25, Marcuse) In both circumstances the corrosive effect on values is predictable:

"To use coercion to maintain the moral status quo at any point in a society's history would be artificially to arrest the process which gives social institutions their

value." (26, Hart)

The scientific-therapeutic complex adopts this coercive strategy when it suits their needs:

"...when the patients behavior represents a threat either to his own life or to the physical safety of others.•.the psychiatrist may have to hospitalize the patient and Impose treatments which at least temporarily help to preserve an oppressive status quo." (27, Halleck)

"The psychotic who hints at suicide or makes self-loathing remarks should be considered dangerous and committable." (28, Solomon)

"...there are occasions when this confidentiality may have to be breached. The outstanding indication is when the life of the patient is threatened, as in acute suicidal states...less clear indications...drug taking or threats to run away. (29, Lewis)

These threats of coercion and detention reveal both explicit and implicit social values. They are part of a movement toward secular "experts" who would forcibly resolve moral issues. The question at large is "who decides what is best for whom?" Should the physician not only advise treatment, but force consent through commitment?

As recently as 1966, suicide was against the law in only nine states. (30, Litman) Yet Schulman (writing in the ABA (American Bar Association) Journal in 1968 categorically states:

"No one in contemporary Western society would suggest that people be allowed to commit suicide as they please

without some attempt to intervene or prevent such suicide." (31, Schulman)

Public consensus is sometimes assumed to justify coercive action. But even a moral majority (if such exists) does not make it lawful. Rather it requires democratic process in the form of open and published law. But what if the law does not proscribe such behavior? In the case of suicide (and more broadly, mental illness) a professional caste assumes extensive parens patriae and police power under cover of civil authority. It justifies its coercive action by appeal to consensus, public benefit, and its own claim to special expertise.

Those who have prescriptive and coercive power (the power to diagnose, treat, and commit) rule those who do not. A political power struggle may emerge, whose character is framed by the current ruling elites. A recent alleged Scientology 'take over' of the British National Association for Mental Health was met by defamatory government claims that Scientology constitutes

> **"a potential menace to the personality and well-being of those so deluded as to become its followers..." (32, New York Times)**

The scientific-therapeutic complex perpetuates problematic features of the social landscape that it claims to resolve. In the super-ordination of prescriptive and proscriptive authority, the individual is rendered a moral defective incapable of free choice and responsibility. Separated from self-determination,

the opportunity for existence based upon understanding is nullified.

"Community thrives on self-help (and also a little disorder), either corporate or individual, and everything that removes a group from the performance of or involvement in its own government can hardly help but weaken the sense of community...But when external absorption of power and function threatens to remove the basis of community...what else but the social horde and alienation can be the result." (33, Nisbet)

At the very least, it must be acknowledged that current approaches to social problems, e,g., community mental health agencies, suicide prevention centers, etc.; with their usurpation of jurisdiction and responsibility, and assumption of coercive authority are incompatible with fundamental democratic assumptions

"The working touchstone of a 'democratic' system of authority is simply the degree to which it gives individuals legitimate instruments for reaching those who make the decisions that affect them, and for bringing influence to bear upon them. A system is more or less "democratic" depending on the number, availability, and effectiveness of these instruments, and on the proportion of the population entitled and able to use them." (34, Frankel)

4) Voluntary Association

The scientific-therapeutic complex operating under state auspices is largely removed from political regulation and oversight. This immunity may be mitigated by the development within each profession of counter-current theories and critiques. But this merely subjects

citizens to further professional incursions.

An alternative to control by presumed experts with coercive power emerges in individuals, groups, and agencies that actively eschew coercion and political and moral elitism.

"The necessity of organizing the social world in terms of political power is not a fact but a supposition." (35, Reichert)

The theory behind such a movement is founded in the traditional of voluntary association. A rationale for this alternative in addressing suicide is illuminated by the observation that

"All force, is, in the last analysis, based on the power to kill. I may not kill a person but only deprive him of his freedom...whatever I do, behind all these actions stands my capacity to kill and my willingness to kill..." (36, Fromm)

While enabling a commonality of concern, the denominated "powerless group" is able to cut across the usual institutional and professional lines. Such groups engender intuition, reflection, conviction, perspective, and compassion - in contrast to power-bound groups which develop logic, direction, action, and enthusiasm. The rules for the powerless group are self-determined, and the purpose of the group is to increase understanding in the context of community. (37, Crenshaw)

Such a group is not necessarily bereft of direction and action and enthusiasm. Alcoholics Anonymous (AA) is

witness at-large to the ability of simply structured volunteer groups to effect programs of remediation. If power is the capacity to do work over time, then "powerless" is a misnomer. (38, Paulson) The point is that such groups function autonomously - neither attempting to seize, nor using political power for their purposes.

The development of Suicides Anonymous was galvanized by this tradition. Vowing non-coercion, emphasizing mutuality in relationships, and working with non-professional volunteers, SA exemplifies an organization in the service of human life, life with understanding and dignity, life based on self-determination.

5) Conclusion

Many difficulties that confront agencies in the realm of human problems and social conflicts are traditional and practical (time, money) and socio-political (turf). Some issues are conceptual creations, especially those that claim resolution through moral or therapeutic expertise. Here is a list of seven agency pitfalls:

1. Metaphors which paint and parcel a unitary client, ignoring the inter-phase, interaction, and variegated meanings of persons and situations.

2. Established delivery systems - governmental units, mental health associations, and community resource services (e.g., Community Chest) which solidify existing

goals and discourage innovative and local effort.

3. Efficient goal-oriented, specialist manipulation of subjects as experimental variables versus persons with both existing and emergent of coping capacity.

4. Organizational hierarchies which position the client (patient) at the bottom of the coping scale.

5. Embedded leadership which delegates blame for irresponsible decisions.

6. Coercive authority reinforcing death-wish introjects and projects.

7. Therapeutics contrary to participatory democracy and incompatible with civil liberty.

American political history demonstrates strong reliance on coercive manipulation of lawful but socially unpopular behaviors. This element is most pronounced in compulsory government education and military service, with analogues in family governance and local 'home rule.' The expansions of the coercive expert prerogative is in large measure the result of a diverse secular base demanding a non-religious rationale for painful interventions after the failure of alternative institutions.

The resolution of these difficulties may be found in apolitical, non-professional, non-coercive service organization based upon egalitarian and liberty interests of and for volunteers and clients. This transforms the

task of such an agency from 'suicide prevention' to 'living with aware affirmation.' Structural attributes of such organization include minimal rules and strongly affirmed principles affording optimal opportunity for innovative and responsive engagement.

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Section III. Anonymous Ethics

"Don't let them tell us any stories. Don't let them say about the man condemned to death: He is going to pay his debt to society! but: They're going to chop his head off. it may seem like nothing. But it does make a little difference. There are some people who prefer to look their destiny straight in the eye." (1, Camus}

"To use coercion to maintain the moral status quo at any point in a society's history would be artificially to arrest the process which gives social institutions their value." (2, Hart)

"We are all robots when uncritically involved with our technologies." (3, McLuhan)

Personal anonymity is first-off a consequence of marginal social-cultural participation and mechanized production for increased efficiency which encourages product and worker uniformity. But idiosyncrasy is disruptive and costly to well-defined roles and regulation, hence stimulating recognition (definition, diagnosis) and coercive intervention. Conditions of revolution, war, financial crisis, and personal upheaval create immense pressure for conformity and beget renewed regulation.

Yet these conditions also create a counter-force for independent judgment and conscientious objection. Calls for corporate "social responsibility" and organizational accountability intensify when large segments of the public become disillusioned with established practices and rituals. Changing expectations and altered

sensibilities serve as new reference points for critical evaluation of problematic practice under these circumstances.

As consensus erodes, issues of fact and value are confused or distorted and alternate claims as to organizational ethics subject previously accepted benchmarks to strain and incredulity.

In the 1950's, a perceived thermonuclear threat led to the construction of numerous public and private underground bomb shelters. This generalized impulse to secure a future not only for our own lives, but life itself, is exaggerated by the insecurity of job roles and ambiguous regulations that guide our lives. Guilt by association is used to denigrate opposing interests, as in the suggestion of a post-war communist conspiracy to overthrow the government, or covert collusion with the military-industrial complex on the part of presumed 'independent' educational institutions (M.I.T., Stanford, Syracuse) conducting government funded research during the 1960's.

But just as an organization may play multiple roles, each role may be invested with multiple social meanings, i.e., it may be interpreted in a variety of fashions corresponding to implicit rather than explicit values. Hence a prison, a concentration camp, or the military may assume a benevolent role, i.e. treating its captives 'well' provide nurture and nourishment, dignity and

humanity. Pressures for change often derives from rendering implicit values explicit.

For example, the labels 'prison' and 'concentration camp' designate coercive authority, but not the manner in which that authority may be exercised. This is revealed in the behavior of the organization and its personnel and clients. What an organization 'does' provides an initial basis for value recognition, both covert and overt. However, ethical judgments depend heavily upon interpretation of those behaviors.

Divergent interpretations are often attempts to mold consensus and rework institutions along newly formed foundations of such 'understanding.' Especially suspect are theoretical constructs where facts of operation are withheld from public view. One example is interpreting prevention as benevolent action, construed as community mental health under protective medical oversight.

Conflicts of interest between lover, family members, gangs, and bosses described in medical terms and judged by medical ethical appeal is essentially a denial of individual responsibility effected by the mitigation of civil liberty.

Freedom

Freedom is personal and agency power confronted by opposing matter (rocks, creatures, property), other persons (individual, neighbors, children, immigrants),

organizations (private, public, government) Disputes about freedom are questions about the arrangement and distribution of power between and among these diverse bodies. Any contractual (lawful) redistribution of human freedom is dependent upon two salient features: (1) awareness; and (2) agreement.

Awareness cannot create or guarantee freedom. In a limited sense it renders it possible through the initiation of behavior (individual), and the rule of law (social). Awareness is mental process, both understanding (subjective) and knowledge (objective) of difference and distance; of isolation and community. Absent awareness of difference (of strength, opinion, economic status, etc.) there is little motive for protection by alliance or consensus. Awareness allows us to direct and delimit our energies, to respond to environmental differentials, to exercise our capacity for choice.

To be free from unwanted imposition and free to apply our energies requires agreement. Agreement is the reconciliation of difference. There is no need for agreement where there is no difference. "Informed consent" is a highly evolved surrogate for agreement, a formal linking of individual awareness and agreement for action.

<u>Freedom and Security</u>

But agreements are subject to re-interpretation.

Different levels of awareness or social status (child-adult), or changes in others obligations may render them null and void. Agreements unsupported by the imposition or threat of overt power generally depend upon virtue and character. This insecure state of affairs leads to development of binding laws; i.e., coercive agreements called 'contracts' with penalties for failed performance. Such agreements also generally provide for contractual revision or nullification in order to accommodate altered circumstances and synchronize practice and reality.

Whereas current circumstances generally motivate agreements with a view to mutual future advantage (purchase agreements), some agreements are specifically made to forestall expected future consequences of no agreement (bail bond). The latter is the domain of prevention and security.

The law of contract, contrary to the rule of force or the power of fraud, secures an arena in which one may predictably operate. It is an extension of the belief that freedom is valuable only when secured; and only secured when backed by coercive authority. These premises, though suitable enough for hostile or indifferent relations, can not account for the much more numerous amicable, loving, and voluntary agreements, many of which are equal to or more secure than those bound by contract.

Contract warrants (promises) freedom where adversity,

scarcity, and competition are operative. In such a culture, overt suppressive forces (police power) thrive in order to mitigate violence and reconcile conflicts. But at the same time, these interests depend upon repressive civil measures such as compulsory education to entrain consensus. By the manipulation of consensus and the identification of popular needs with those of a controlling elite, freedom is stifled.

Such tactics fail in the longer run for two divergent reasons. Elite interests, for advantage, profit, and diversion, manufacture an illusion of scarcity. As psychological scarcity and its correlate, the compulsive need to consume, gain momentum, the growing gap between expectation and fulfillment induce a hostile mass awareness. One example is 'Black Power", a movement to seize a piece of the pie: job, home, two cars in the garage, a color TV etc. Local political control is a demand to rectify the mal-distribution of wealth needed to satisfy the induced appetite. The apostles of growth through capitalism thus sow the seeds of revolt which demands social control over the means of production and distribution.

The second elite error is repression through universal compulsory education. Analogous to infant baptism, the purpose of this scheme is to create a citizenry a life subscription systems and values, methods and structures that are renewed by ritual participation

at lower levels and entry into the freedom club by the select few at higher echelons. This fails because the "elite" themselves are bound in roles with marginal independence in huge bureaucracies with marginal opportunity 'at the top' to rectify the powerlessness of childhood implicit in higher education.

The rising young middle class also experiences intense dissatisfaction with (a) environmental pollution, war, poverty, and (b) strictly adversarial competition in play, sport, and work; (c) non-participatory democracy with extended childhood dependency, absurd voting age requirements, systematic age-based discrimination in law, finance, business, government.

On the other hand, youth is invigorated by the prospect of (a) alternative cultures and (b) the rediscovery of latent modal sensibilities; e.g. touch, sex, sound, and psychedelics which (c) animate new awareness, establish new priorities, and create pressure for revaluation of age, race, and gender relations. This is a revolution in expectations, agreements, structure and politics which features personal satisfaction and social innovation. By this development, the state is marginalized. But this attitudinal change suggests mist seeking form. It particularly lacks historical and pragmatic perspective, a utopian heritage rife with delay, attrition, carnage, and extermination, and defeat by attrition.

Politics may not be ignored. Freedom under conditions of constitutional representative democracy demands limits on State authority and publicly published laws; these are conditions necessary to freedom warranted by contract. Hence the importance of awareness and informed consent as critical elements in the ethics of organizational structure, actions, and interactions.

The State, Contract, and Coercion

Ethical organization reconciles conflict within and external in accord with overarching civil rules, i.e. established contracts. Since such rules may dignify involuntary servitude, the "ethical" organization may assume the posture of slave-owner. This is the state's role in relation to prisoners, convicts, conscripts, some juveniles and mental patients held in pretrial or preventative detention.

In a federated union there are many states and delegated authorities, but all derive their authority from their lawful relationships with their own constituency and the Federal Government. Insofar as organizations, groups or authorities utilize coercive tactics, they are either operating illegally or under authority derived from the state. Conflicts between grants of authority, or presumed absence or breach of authority are established based upon a hierarchy of law and interpretation at whose summit presides the Supreme

Court, trustees of the Constitution.

In this country it has been customary to ignore the priority of constitutional principles in delegating authority to organizations other than the State. Mental hygiene and drug addiction statutes, as well as tax, draft, and compulsory education laws present several cases in point. Whether it is physician sentencing you to an indeterminate period in a mental hospital or a civilian review board taking involuntary conscripts, or a truant officer dragging you back to school, the extension of governmental powers via subsidiary agencies, into areas contrary to Constitutional provisions appear is clearly illegal.

Yet our system of law maintains a high barrier against individual construction of legality within this exalted realm. The opportunity for judicial scrutiny and determination on legality are fettered by doctrines of standing, ripeness, and moot; and by statutes with stringent limits on declaratory judgments or injunctions. Finally, Judicial doctrine dictates that decisions be made on the narrowest grounds possible, therby avoiding Constitutional interpretation. The consequences of resistance and invalidated interpretation are profound and devastating.

Delay and difficulty does not justify violence or even local or idiosyncratic legal enforcement - a process that takes place both within established governmental

structures (Chicago "police riots" of 1968) and external to them (Ku Klux Klan, Weatherman, etc.)

Given well-established cultural traditions of hugely expensive, long-delayed, flawed and failed legal process, individuals and organizations need to reassert responsibility for asserting the priorities express in both federal and state constitutions. Withholding judgment until the highest appellate court makes a ruling demonstrates well how prevailing interest easily usurps and corrupts principled action.

The suicide prevention agency or physician claims a professional duty to coercively prevent an individual from suicide. Isn't this the equivalent of canonical regulation which imposes moral regulation and ignores consent which is the basis of treatment? What must be the corrosive moral effects upon 'helper' institutions that indulge this presumption?

By its regulation of health and welfare the State may coerce, quarantine, and even impose time-limited service when emergencies are anticipated or supervene. But such authority amounting to incarceration is not justified by marginal social alterations of interpersonal relationships. Shall the voluntary patient be locked into a 'hospital' for sharing the truth and admitting to suicidal thoughts? I recently spoke with a 45 year old woman prepared to leap from a window to escape 'her' captor physicians holding her in opposition to her

express desire to leave the University Hospital operated under the auspices of the State University of New York. Her physician rationalized her restraint since he didn't want to incur any liability to the hospital (or himself) if she succeeded in hurting herself!

Preventive detention in a hospital sanctioned by court and statute emphasizes convenience and expedience over Constitutional principles. Asserting its interest in the patient's welfare, the state manipulates physicians and institutions, holding than to standards of behavior contrary to professional ethics and in blatant disregard of the express intent and civil rights of those who enter into a voluntary relationship, only to be forcibly detained.

Is there a way in which a state might protect its considered interests, without engaging in deceptive if not illicit delegation of coercive authority? Two possibilities: (l) Indemnify victims broken contracts to which the state is a party. For example, the state compensates the families of deceased war veterans. (2)Redefine as criminal those behaviors the state considers unacceptable. Behavior explicitly proscribed and penalties clearly defined are conditions fundamental to due process. If the government enjoins suicide, any sanctions should be manifest and published, and any incarceration criminal.

Finally, coercion is a facile response to non-

aggressive conflicts of interest. Wherever differences may be joined without resort to coercion, a free citizenry must resist the intrusion of the State or its agents. On its part, the state must disavow coercion when it engage in advice, arbitration, or persuasion, except when imminent danger to the state is threatened.

Coercive intrusion hardly disappears with limitations of state authority or its abolition. Surrogates are spawned in criminal mobs, financial oligarchies, or political parties with minimal public scrutiny, participation, or controls, e.g., rogue gangs, financiers, and political parties. The National Socialists Workers Party in Germany and the Soviet style Communist Party are notorious for secret police and concentration camps.

To the extent that institutions perform distasteful but legitimate coercive functions, their revaluation under new acceptable labels is predictable. But the dialectic of 'newspeak' is also a shroud whereby war is prevention for peace, and brutal atrocity identified as public virtue and prevention of terror.

An alternative to suicide prevention which is actually the deprivation of civil liberty, is confirmed in egalitarian, democratic cooperatives based upon and volunteer participation. This creates a viable alternative to coercive statist and devolved expert solutions. This is the agency of Suicides Anonymous.

Informed Consent and Organizational Awareness

Awareness is a minimal condition for the existence of human freedom. The unconscious person is not capable of choice. Developmental disability, and partially conscious or altered states of awareness, e.g., sleep, drug induced, dissociative states, present a broad diversely inhabited borderland realm. Generally in our society, free choice and personal responsibility for behavior are presumed. With the exception of legal minority, anything contrary to this presumption must be supported by clear and convincing evidence.

The right to engage and disengage in/from lawful consensual agreements represents the sovereign right of any citizen upon reaching legal majority. The individual may enter into some agreements which others may interpret as tantamount to slavery. But if these agreements are lawful, they may also be broken unilaterally, with the consequences prescribed by the law. In France sleep research volunteers undergo four months in a cave. In England volunteer spent seven months in a coffin. We may believe these persons misguided, their right to engage in such 'folly' can not be denied.

Patients here may voluntarily enters a mental hospital, put in a locked box under conditions of chemical, legal, or physical restraint; then only to discover they are not able to leave, i.e., legally converted without their consent to 'involuntary' status.

Upon discharge, the "mental patients" will be subject to added scrutiny in the application for a job, or their fitness for military service. These are elements that are often called 'stigma,' but should be part of a full explanation and consent of any person to mental hospitalization.

I have friends who consider a job with any large institution a form of slavery. Do they have the authority to declare me "incompetent" or "insane" because I am trained and employed in a state institution (I could well see their point)? In truth, how could I know what I was getting into? The state is mutable, secret, inaccessible; my awareness can only be minimal. There is no justice to any person by enjoining lawful agreements which they consider desirable. What if our cave or coffin volunteer wishes to come out before time is up? The determinative issues then is not whether one is free to enter, but whether free to leave.

It follows from the largeness, complexity, secrecy, and policy of many organizations that awareness and informed consent upon entry is a practical impossibility. A friend of mine, when applying for a job, would routinely ask the organization representative for disclosure of its connections with the military, and its hiring and firing policy regarding racial job discrimination. His questions were not tolerated. He was not hired. Yet those same organizations made inquiries

into his credit standing, past mental hospitalizations, criminal record, private life, and suggested that he cut his hair if he expected to get a job. The arrogance of organizations is legion. It is not unexpected since we so placidly accept these status inequities which degrade our freedom.

Another friend of mine, a resident psychiatrist at Upstate Medical Center in Syracuse, was informed that his contract would not be renewed for his third year of training. Despite repeated request, he was denied access to reports that were the basis for his dismissal. Thus deprived of the opportunity to defend himself against the claims his possibility for understanding was denied and his character defamed because that "would hot be in his best interests." Whose best interests? Both the ethics of medicine and the ethics of education demand disclosure of this sort. But organizations and institutions perpetuate conditions of ignorance which deny to the individual the very possibility of awareness and choice.

Open Disclosure

Agencies that are aware of their role and operations can meet the responsibility of disclosure, not only to the public and clients, but perhaps most important, to their own workers. Institutions must be honest and open with their own, if freedom is ever to become a reality for the persons served.

The public face of organizations conceals much that is self-serving expedience. The declaration, 'we're only trying to help you' is a mantra to re-assure its own workers who must set the lure; and mitigate culpability for entrapment with all its secondary adverse consequences.

Organizational hierarchies promote efficiency and leadership durability by upward disclosure of confidential information. They are risk adverse, and crush the potential for individual creative attachment which is the principle motive for life-affirmative change. These elements are exemplified by marginal life-style regulations (dress codes, etc.) which serve as exemplars of corporate loyalty; and at-will employee terminations accompanied by ritual justification codes for dismissal.

In the final analysis a review of the ethical character of agency organization is suggested along the lines herein proposed. Such a review would trace the relations of agency to agency, agency to workers, and agency to clients. It would inquire:

(1) What does the organization claim to be? What is its model, goal, and method?

(2) What does the the organization actually do? Its role in the Community, in politics,

(3) What is the agency's relation to government authority?

(4) How does the organization's awareness measure up to outside description of its activities? Does it impart this awareness to its workers? Its clients? Its community?

(5) Does the organization discriminate between questions of fact and those of value?

(6) Does the organization apply consistent principles of behavior to itself?

(7) Is the structure of the organization implicit or explicitly hierarchical? Does it militate against openness and awareness?

(8) What are the penalties for disengagement? For innovation?

Liberty Ethics

Examining, interpreting, and evaluating the ethics of an agency is a complex exercise in (a) fact gathering; (b) behavioral interpretation, and (c) evaluation based on fact and interpretation.

Ethical claims are confusing because the element of interpretation usually carries a heavy burden of covert cultural values. The task of organizational ethical analysis is to make clear factual basis and bias, both in terms of the selection of behavior examined, and the varied perspectives in virtue of which that behavior acquires meaning.

Disputes over final evaluation are usually based on

the initial steps of data selection and interpretation. For example, a focus on physician restraint rather than the time spent talking with or ministering to patient underscores the diverse facts which may be scanned into the results. If the physician's primary perceived institutional role is counselor, drug dispenser, or jailer, then valuations may be markedly divergent.

Plausible interpretation rests heavily upon a pre-existing consensus of values and even less likely to receive critical examination than fact-finding. Buried or hidden cultural expectations and taboos, especially those "beyond dispute," are perhaps the most dangerous element in ethical ascription, obscuring the distinction between fact and value.

To justify behavior we dignify slippery interpretations with ethical injunctions. Moral outrage secures political space to build, conquer, and defend in the name of truth. This process at first appears to stifle and retard the evolutionary and innovative nature of cooperative humanity. But minority judgments plant new seeds of change. On such babble-rubble morality is once again rendered immortal. (4, Brown)

Suicides Anonymous attempts to counter religious, statist, and medical interpretations of suicides characterized by dogmatism, diagnosis, coercion, and involuntary hospitalization. The enunciation of civil liberty interests suggests the potential for interactive

and proactive agencies dedicated to life with awareness, choice, and self-determined meaning.

Suicides Anonymous: Summary Analysis

Facts

(1) client anonymity and confidentiality

(2) non-coercive agency

(1) volunteers responding to calls

(2) local outreach

(3) group discussion of emergent problems

(4) shared suicide current knowledge base

Goals

(1) empathy, mutuality, and trust

(2) encourage self-initiative

(2) preserve of life with meaning

Interpretation

(1) autonomy of workers and clients

(2) personal relationships more important than organizational status

Evaluation

(1) nominal structure aids in clarity of purpose

(2) respect for confidentiality reduces communication and inhibits organization morale and innovation

(3) Decentralized function and volunteer autonomy enhances personal responsibility for actions

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